

# EMPLOYEE ERGONOMIC HISTORY

Date:	Time:	Employee:	Employee Badge Number:
Building/Office:	Phone Number:	E-mail Address:	
Job Title and Task Performed:		New Employee	<input type="checkbox"/> Yes <input type="checkbox"/> No
		New Workstation	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Do you routinely experience discomfort or pain	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please check all that apply:

Body Part	Left/Right	Severity of Pain or Discomfort <sup>1</sup>	Frequency of Pain or Discomfort <sup>2</sup>	Medical Treatment Received	Date First Noticed	Comments/Description (Describe Treatment Plan)
A. Hands/Wrists /Fingers	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> Y <input type="checkbox"/> N		
B. Elbows /Forearms	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> Y <input type="checkbox"/> N		
C. Shoulders	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> Y <input type="checkbox"/> N		
D. Legs	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> Y <input type="checkbox"/> N		
E. Neck		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> Y <input type="checkbox"/> N		
F. Upper Back		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> Y <input type="checkbox"/> N		
G. Lower Back		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> Y <input type="checkbox"/> N		
H. Headache /Eye Strain		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> Y <input type="checkbox"/> N		
I. Other		<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> Y <input type="checkbox"/> N		

<sup>1</sup>Severity: 1 = Mild (noticeable discomfort less than two times per week for less than 30 minutes per event)  
 2 = Moderate (noticeable pain on a daily basis for less than 30 minutes)  
 3 = Severe (noticeable pain greater than two hours per day that subsides with over the counter medications)  
 4 = Unbearable (noticeable pain that debilitates or is continually present)

<sup>2</sup>Frequency: A = Seldom (one time per week)  
 B = Often (three to five times per week)  
 C = Always (daily)

J. Do you feel pain/discomfort is related to workstation setup or equipment? ☐ Yes ☐ No  
 a. If no, what do you feel is causing problem?

K. Previous injuries or treatment to problem area and pre-existing medical conditions (arthritis, diabetes, pregnancy, etc.):

L. Outside activities (Hobbies with a history of stress factors such as: softball/baseball, racket sports, bowling, cycling, golf, painting sanding, playing musical instruments, sewing/needlework, gardening, weightlifting, etc.):

M. Do you experience any pain due to these activities? ☐ Yes ☐ No

N. Do you have a home computer? ☐ Yes ☐ No Hours used per day on average:

O. Do you smoke? ☐ Yes ☐ No

P. Please provide additional information that may be relevant to your discomfort: